Health Information Technology Standards Committee
Final
Summary of the July 20, 2011, Meeting

KEY TOPICS

1. Call to Order

Judy Sparrow, Office of the National Coordinator (ONC), welcomed participants the 27th meeting of the HIT Standards Committee (HITSC). She reminded the group that this was a Federal Advisory Committee meeting, with an opportunity for the public to make comments, and that a transcript of the meeting would be available on the ONC Web site. She conducted roll call and then turned the meeting over to National Coordinator for HIT Farzad Mostashari.

2. Opening Remarks

Mostashari described tension between the maturity of standards and their adoptability. Mature standards developed over a period of years have become increasingly sophisticated and meet many very specific use cases very well—and yet some of those standards have not become widely adopted. There also are standards that may be still nascent and yet are experiencing incredible adoption rates. In the early stages, it may be that leaving things underspecified, flexible, and extensible may help at least the early adopters take interest and ownership of a standard. There is a question of whether linking what is happening in health care more to broader standards that have been adopted in other industries would perhaps accelerate adoption. Mostashari indicated that the HITSC is an appropriate venue for this discussion.

Mostashari explained that if the only lever that is available in terms of standards is certification criteria and standards for all electronic health records (EHRs), then that places a very high bar, certainly for adoptability and probably for maturity as well. Are there other ways to innovate, move forward, and recognize standards that are very mature and perfectly suited to very specific use cases but do not meet the test of adoptability for every EHR in the country? Or should standards that are closely linked to what is going on in other parts of technology that are not yet specified well enough for health care use be recognized, with the development of a process for getting them matured quickly? These issues comprise much of the work with which the Standards and Interoperability (S&I) Framework is engaged.

3. Review of the Agenda

HITSC Chair Jonathan Perlin noted the need to aim for a balance between innovation and what exists now, between probability and possibility. He welcomed a new HITSC member, Rebecca Kush, President and CEO of CDisk.

HITSC Vice Chair John Halamka briefly outlined what has been accomplished and what work remains for the summer camp activities, and then reviewed the day's agenda. He noted that next month, the Committee will have a call-in rather than an in-person meeting.

Perlin asked for additions or corrections to the minutes from last month's meeting. Carol Diamond indicated that she found a misattribution, and e-mailed her correction to Judy Sparrow.

> **Action Item #1:** The Committee approved by consensus the minutes from the June 22nd meeting with Carol Diamond's corrected attribution.

4. Clinical Quality Workgroup and Vocabulary Task Force Update

Clinical Quality Workgroup Chair Jim Walker presented an initial update, indicating that final recommendations will be presented in August. He then presented the three levels of tasks facing the Vocabulary Task Force:

1. Identification of vocabularies, so that developers and standards organizations have a place to start.
2. Identification of which of these would become part of the HIT certification requirements.
3. Identification of which of these would be required for care delivery organizations to meet meaningful use and other needs.

For the purposes of this meeting, Walker focused on part of the first item: what is the minimum necessary set of vocabularies for creating quality measures? The Task Force also is examining a related question: in some vocabularies, is there a partial depth that should be indicated, rather than use of the entire vocabulary?

He walked through the group's discussion about the desiderata for code set standards:

- Interdisciplinary applicability. If it doesn't work for the whole healthcare team, it creates problems.
- Minimal necessary maturity. Related to this is the question of what makes it mature? Logically mature? Technically mature? Is there some kind of implementation experience with it to suggest that it is implementable?
- Maximum ability to accommodate innovation. The goal is to have the minimum necessary number of code sets so that people know where to focus.

Walker then presented the recommended code sets in a number of areas, such as adverse drug effects, patient characteristics, devices, non-lab diagnostic study results, communication, patient experience, family history, functional status, etc.

He noted that throughout, Logical Observation Identifiers Names and Codes (LOINC) and the Systemized Nomenclature of Medicine (SNOMED) make a nice pair. LOINC is the survey instrument, and SNOMED provides appropriate responses. With regard to the use of the term "encounter," Walker said that this almost suggests a billable activity. Clearly, if they are going to have maximal ability for innovation, then an "encounter" needs to include every kind of interaction between patient and any kind of clinician. More and more, these interactions are not going to be not encounters in the classic sense. The Task Force kept the word "encounters" so that everyone would know where they are in the discussion, but it essentially represents any patient-professional interaction.

The Vocabulary Task Force will be discussing whether Current Procedural Terminology (CPT) is acceptable where appropriate, making it clear that SNOMED is the direction they are headed, but that CPT will possibly be left open for organizational feasibility for meaningful use Stage 2. The group does not want to create an impediment to having meaningful use Stage 2 specified and implementable by care delivery organizations.

With regard to "transfers," the Task Force is referring to any transfer of a patient from any one place to any other, anywhere across the spectrum of care, in what they hope is a forward-looking definition. For this, SNOMED was clearly the appropriate vocabulary.

Discussion

- It was noted that when this group considers standards, they are thinking of the ways in which things are represented between organizations. If the Unified Code for Units of Measure (UCUM) is intended to be a language to standardize for exchange, does that preclude using the International System of Units (SI)? Not having a corresponding underlying unit can lead to errors. Is this an exchange standard, or does it go deeper?

- One Committee member noted that meaningful use Stage 1 focused on medications, allergies, drug interactions, etc., and asked if the recommendation to expand allergy and non-allergy includes all those other use cases? Walker explained that the Task Force was looking for the maximal way to support innovation. This recommendation can serve as a pointer for people who are engaged in development in areas dealing with these additional use cases, versus a requirement for meaningful use.

- Another Committee member said that in meaningful use Stage 1, Clinical Vaccines Administered (CVX) was adopted as the vocabulary code set for vaccinations. Implicit in this is to change meaningful use 1 and migrate to SNOMED CT. Is there discussion about moving to a new standard? Marjorie Rollins indicated that this discussion took place, and that maps are available for transitions in general. Walker acknowledged that this is an area that is more complex than many others, but the clear consensus was that it made sense to have vaccines in RxNorm.

- David McCallie commented that appears to be overly simplistic to specify simply LOINC or SNOMED. Some type of grammar is needed for computability. One cannot pick any LOINC or any SNOMED and think that is going to be computable. Stan Huff agreed, saying that models are always needed to make those necessary connections. The Task Force is not indicating that the simple specification of LOINC will bring about true interoperability. Within a year or 2, there should be consensus on these types of models.

- Clem McDonald indicated that it may not be beneficial to break the fairly wide adoption of CVX. Perlin noted that this points to the need for more contemplation about CVX and LOINC. When the times comes, the Task Force will need to work with the ONC and the Health Information Technology Policy Committee (HITPC) on the notion of substituting one for the other.

- Doug Fridsma noted the need to resolve some of the issues regarding what was adopted in meaningful use Stage 1, and what that migration path might look like. He pointed to the item about devices and the fact that it specifies SNOMED for now, but does not specify what might be next. They need to be careful about specifying new vocabulary sets every 18 months. Is there something else coming down the pike?

- Wes Rishel praised the group's work, saying it is valuable to have the entire overall scope of these issues pulled together in one place, with a strategic set of variations on how to approach them. He clarified that UCUM is not a unit of measure, but a grammar for expressing units of measure. Stan Huff noted that Intermountain Health Care has been using UCUM for a long time. The way to implement this is to make it a standard coded field in software. He explained that it is exactly analogous to using any standard coded field in the software.

- It was noted that care will be needed when addressing the historical background of many medical records. A medical history may reference something as broad as a brand of aspirin, or the fact that a patient gets sick when they go to seafood restaurants. What is recorded now may be codable, but the patient's historical information will not be.

- Regarding RxNorm, Nancy Orvis noted that both sub-attributes of RxNorm go back to universal identifiers. Both the U.S. Environmental Protection Agency (EPA) and the U.S. Food and Drug Administration (FDA) have made it their job to make available free identifiers for all substances. These are the same sources that are feeding RxNorm and other trees in SNOMED CT.

- Doug Fridsma pointed to the need for the Vocabulary Workgroup to do everything it can to create an environment that providers, patients, and vendors can trust. To that end, what are the other tools and resources that could make this transition process better? For example, they believe that there are mapping vocabularies between RxNorm and CVX that would be helpful. What other kinds of things would help? They must make sure to provide backup information about tools and resources that will help people to be successful.

- Walker commented that the Vocabulary Task Force has discussed mapping, and that discussion will be more mature in August. The message the group is trying to convey to the Committee at this meeting is: those people who are trying to do this right now need a language to identify a device, and the very clear consensus was that SNOMED is clearly the best there is, even though it may well be superseded. The Task Force also feels that the devices to be specified for measure development in the next 18 months would make up a very constrained list.

- Jamie Ferguson noted that the Task Force has generally indicated that the recommended vocabulary standards should first be put into certification criteria before their use is measured in meaningful use incentive measures. The capability should exist in implemented EHR technology before it has to be actually used and measured. Secondly, the National Library of Medicine (NLM) is already providing many of the subset and cross-mapping resources. The Task Force's guidance should perhaps point to those existing resources.

- With regard to the discussion around devices, it was pointed out that NLM is in the middle of negotiations between Global Medical Device Nomenclature (GMDN) and the International Health Terminology Standards Development Organization (IHTSDO), and they anticipate that GMDN will become a part of SNOMED. Specifying SNOMED in the meantime lets the field mature, until one of these will be a clear choice in the next year or so.

- Steve Posnack brought up a standards policy point. The Task Force must be fully aware of the situation from a clinical quality measures (CQM) development perspective, which comes with an approach for specific code sets. They have made conscious decisions not to align with other code sets that they want for other purposes. General industry feedback has been that that, in addition to the 30 or so certification criteria they have, there are the CQMs, and those could impose additional requirements with their own set of codes. Perlin commented that he understands this reality, and as they move forward, the most parsimonious and practicable approach will be when they begin to develop enough of a base of code sets that the data model then supports the type of data model to which the CQM would aspire.

- Marjorie Rollins spoke from the measure developer perspective regarding incremental paths and getting the vocabularies ready in anticipation for meaningful use Stages 2 and 3. Performance development measures are being prepared now for Stages 2 and 3. Developers have a quality data model, and there is an expectation that performance measures for Stages 2 and 3 should reflect recommendations from this Committee and the quality data model that will result. However, there is a logistical challenge, which may be out of scope but is relevant. The quality measures need to be workable according to these recommendations.

5. Standards Summer Camp

John Halamka introduced this discussion, noting that the National Council for Prescription Drug Programs (NCPDP) script standard for e-prescribing is widely used for retail and mail order pharmacies. Hospital pharmacies use a different method. The challenge for the group, led by Jamie Ferguson, can be characterized by a hospital pharmacy providing a discharge medication electronically—how can they support both this hospital pharmacy and the retail and mail-order pharmacies, and use the fewest standards?

Doug Fridsma said that the Clinical Document Architecture (CDA) Consolidation draft standard has now been approved. He applauded HL7 for driving that forward and being responsive to meaningful use needs. Right now, within transitions of care, they are in a pilot phase and need people to help with these pilots.

In addition to the updates being presented by the various Power Teams at this meeting, Fridsma reviewed other ONC work and S&I Framework activities.

The LRI group has developed a constrained profile regarding an ambulatory guide. The Provider Directory Group had come to consensus on a use case, taking the recommendations of this group and the Policy Committee to heart. The next step is to work on a data model to correspond to the Lightweight Directory Access Protocol (LDAP) and the Health Device Protocol (HDP).

The Certificate Interoperability Group is looking at the federal Public Key Infrastructure (PKI) policy. They are exploring with the General Services Administration (GSA) and others the issue of updating federal PKI policy to adopt to this certificate and seeing how that would work with the federal bridge and the like.

Query health and data segmentation are in pre-discovery phase. They are looking at charters and examining the current environment.

Fridsma noted that additional information on every S&I Framework project is available online. Halamka referred to an entry in Wes Rishel's blog about "sending questions to the data." As they think of models, they could either aggregate all records in a giant database, or they could send the question to the data and aggregate the results. There are use cases where each of these is a good idea.

ePrescribing of Discharge Medications Power Team

Power Team member Scott Robertson presented the group's findings and recommendations (included in a letter to the Committee), which are as follows:

- Align standards for discharge eRx with CMS standards for Medicare Part D.
- Align standards for medication history used in discharge eRx with meaningful use and EHR certification standards.
- Align standards for discharge prescription medications eligibility and benefits with the Health Insurance Portability and Accountability Act (HIPAA).
- Administrative simplification.
- No formulary standard is recommended.

Discussion

- Wes Rishel asked about patient history built through e-prescribing transactions. Do discharge medications follow that route and get into the patient's global medical history? Jamie Ferguson responded by saying that this is one of the reasons the group offers a dual recommendation. They recommend allowing for longitudinal medical history to be used from EHR systems as well as the actual record of what was e-prescribed and dispensed from pharmacies.

- Cris Ross pointed to the various repositories of e-prescribing information and said that if these recommendations were to be implemented, the task would be to join those data sets. Those joins would be straightforward, with the exception of formularies, which do not exist in a standard form in the industry.

- Rishel said that there is enough information in these transactions so that one can weed out the same transaction coming from multiple sources. He also asked about the economic incentive for non-pharmacy benefit manager (PBM) paid or not electronically prescribed data.

- Rishel also said there were very particular recommendations on NCPDP prescriptions, but he does not see the same level of specificity for HL7 messaging. Also, the Continuity of Care Document (CCD) in there is for a different use case. He is not clear on whether the CCD must always be coded, or if they are requiring it to be coded in this case. Jamie Ferguson explained that the language that was used in the recommendation letter was included in other regulations. The lack of specificity in the HL7 messaging for hospital e-prescribing is exactly what is in the Medicare regulation. The ability, but not the requirement, to use it is also in the use of CCD with medical history for patient summary information.

- Rishel asked whether they are creating a recommendation that could lead to certification requirements for EHRs. If so, they are doing the same thing that they chastise everyone else for doing, by saying, "here's a vague recommendation, figure out how to certify it"? One Committee member acknowledged that this is a fair point, saying that medical history today is delivered through an HL7 ADT transaction, so it is relatively well known, even though it is not a meaningful use-certified event. Those who want to implement it can do so in a straightforward fashion.

- It was noted that the NCPDP is a container and a transport method for moving a prescription from a place of prescribing to a place where it will be filled. It is suitable even for internal use within a hospital. For medical reconciliation purposes, HL7 along with CCD and CCR will work. Rishel indicated that this was still not specific enough for certification purposes.

- Halamka suggested an amendment to the recommendation letter and providing a list of suggested HL7 version numbers that would be appropriate. Ferguson said that the ePrescribing of Discharge Medications Power Team can take that back as an additional work item. Their general sense was that they did not want to conflict with other existing regulations for e-prescribing. They will have to look at whether being specific about an implementation guide or a particular message would conflict with existing guidance from Medicaid Part D.

- A committee member raised a flag about the question of research use cases in a population context associated with aggregated repositories. The aggregated data has no meaningful way of being implemented for research, because there is no consent status and no metadata for it. Some states object to secondary use of this information.

- Scott Robertson pointed out that ideally, an order should not be sent to the pharmacy until it has been finalize. Also, there are associated messages that can be sent with prescriptions. He acknowledged that these are workarounds, and not good as the ability to receive cancellation messages.

- Perlin emphasized that the group must understand that its first imperative is no patient harm. There will always be a role for human interaction.

- Walker explained that with the current system, a nurse is going to check the discharge prescription against the final care plan, tearing up and throwing away any prescriptions that have become obsolete. What the Team is proposing to do is disconnect the critical safety

human in the process, and automate it. When a system is automated, it creates the potential for rapid, catastrophic failure. They are taking a system that has an explicit safety step and removing that step.

- Kevin Hutchinson said that the charge of this group was to focus on the standards by which information will be exchanged. Three areas need addressing. One is the scenario in which a safety control would be bypassed. This needs to be addressed somewhere, either by the HITSC or HITPC. Similarly, there is a privacy issue: in many states some medications are considered sensitive medications, and cannot be shared without patient consent. Also, not all information is going to be accurate when it is being pulled from various different sources, so there is an issue of access. Issues of workflow, privacy, and access all have to be addressed when looking at this from a safety perspective.

- Mark Overhage noted that the letter specifically recommends the SCD codes, or the RxNorm semantic clinical drug as the way to name the drug. He is concerned because that is the pre-coordinated drug: the ingredient plus strength plus the dose form. He believes that pre-coordination has tremendous negative potential. It poses a problem for patient safety, because of inconsistencies that can creep in when both strength and dose are specified. It also implies that they are going to ask the clinician who is ordering the drug to specify the drug at that level of detail.

- Jamie Ferguson explained that those are the four elements of RxNorm that were previously recommended by NCPDP and by NLM, so that was part of a previous set of recommendations from the Vocabulary Task Force on medical vocabularies for Stages 2 and 3 that were accepted by this Committee. The Team is simply reiterating those here, indicating that the same applies for discharge orders.

- Overhage pointed out the need to fix those previous recommendations. Scott Robertson noted that this has been discussed extensively in a variety of venues, including when NCPDP started considering RxNorm within the standard. When somebody is writing a prescription and they have freeform access to everything, then the specification of actual tablet form strength might not be relevant. But when one is working in a system and products have to have an associated strength, then it becomes incomplete if one does not know the product strengths one is working with.

- Overhage pointed out that formularies are not comprehensive, they are representative, so therefore a user is not going to know what is or is not available. The Team appears to be indicating that every provider, every time they write a prescription, must take the time to choose a specific product, and not simply the drug they want the patient to receive. This is contrary to driving towards generic prescribing where appropriate. Ferguson clarified that the recommendations do include a generic drug name and package, as well as branded.

- Halamka suggested that to bring closure to the letter before the Committee, that the Team simply state that the vocabulary is RxNorm, and version it, and not list the controversial subcomponents. Ferguson indicated that this is acceptable for the letter, but reminded the group that this is already an accepted recommendation in order areas. This is an issue for the

Vocabulary Task Force to revisit, because it was a widely vetted recommendation in a number of different areas.

- Clem McDonald pointed out that the government systems like Tricare, Medicaid, the Veterans Administration, the Army, and the Department of Defense do not provide a system for obtaining patients' e-prescribing information. He suggested that they either use with Surescripts or build a parallel system so that that information becomes available.

- Cris Ross commented that good informatics principles would argue against coordinating drug and dose in single field.

The Committee endorsed the ePrescribing of Discharge Medications Power Team's recommendation letter with two amendments:

- Attempt to specify HL7 version numbers.
- Specify RxNorm as general guidance, leaving out the four specific items in the letter after the colon.

> **Action Item #2:** The Committee endorsed the ePrescribing of Discharge Medications Power Team's recommendation letter with the two amendments as noted.

Patient Matching Power Team

Mark Overhage presented an update from the Patient Matching Power Team, noting that the group has arrived at two principles: (1) for a focus on the direct patient care use case, acknowledging that they need guidance from the HITPC, their thinking is that specificity is more critical than sensitivity; and (2) they must not preclude innovation and growth as other metadata evolves that could be potential patient identifiers.

They discussed what core matching fields would be appropriate, including name, gender, zip code, etc. These will be useful in certain scenarios. However, when trying to retrieve data that is or could possibly be more than 1 year old, literature suggests that other, more stable fields are needed, like a social security number. Other optional attributes that may turn out to be useful are telephone number, or perhaps some future cyber identifier might turn out to be helpful. The full middle name option is being explored, but there is not enough data yet to justify its recommendation.

With regard to data quality, Overhage said the registration process needs to serve as a consistent method of providing unidentified data. In many systems, data is polluted when false information is put in to substitute for unknown information. For example, some people use the convention of entering zeros or the like if a date of birth is unknown. This misinformation has potential implications for registration systems and EMR vendors over time.

He said that last months' feedback from the Committee was helpful: the Team is now stipulating that it should be possible to have patients check their own information to identify data quality

issues. Consistent with previously approved or discussed recommendations concerning data formats and contents, the CDA R2 header format seems to be a robust, useful way to represent these attributes in a query.

Overhage concluded his remarks by noting that a draft letter should be ready for the Committee's review by the next meeting.

Discussion

- Carol Diamond asked for clarification about what was meant by "core" requirements. Are these things that everyone should be collecting? Overhage said that for the patient care scenario the Team focused on, to achieve a good tradeoff of sensitivity and specificity, those are the fields that the literature would suggest are needed. Diamond expressed concern that they are suggesting that these specific fields might be necessary for patient matching. She is also concerned about returning information to the "querier" that the querier does not already have in order to adjudicate the match. If the querier does not know information in other fields, then the system should not return that information to the requestor.

- Overhage explained that the question is one of how to provide a balance of sufficient reassurance and confidence in the information such that the provider who is interpreting the data can use that information in a dialog with the patient to ensure that errors are not being made, and to help in a dialog with other providers. Some public information (name, zip code, etc.) is needed for effective communication. Other information, like the social security number, are not in that category.

- Halamka pointed out that there are concerns about social security number as a data core element because immigrants do not have them, and there are identity theft concerns. In the spirit of making recommendations for best practices, he suggested that the Team provide a list of other identifiers that add sensitivity and specificity. He commented that requiring the social security number in the core data set seems overly simplistic.

- In response to a question, Overhage explained that using only the last four digits of the social security number loses several percentage points of matching accuracy according to the studies they have reviewed.

- Diamond said that additional information should be asked of the querier, not provided to the querier.

- Ann Castro pointed out that the return of a multiple list as a result set with any additional data other than what was entered is disallowed by HIPAA.

- Jim Walker suggested that a previous address would be very useful, at least for the confirmatory phase. They could use that even as a core element.

- Dixie Baker suggested changing "maiden" name to "alternate" name.

- David McCallie said that they focused on the semantics of a query where someone is trying to match a patient. Does the Team's charge also include identifying what should, in fact, be captured and remembered about a patient? Halamka said that they are not going to require that everyone use a single algorithm, but that people understand the range of possibilities based on this guidance.

- One Committee member noted that high-quality data matching will not occur based solely on standards. The information going in will have to be sufficiently robust. One certification criterion could be the expectation of a certain data quality level.

Surveillance Implementation Guide Power Team

Surveillance Implementation Guide Power Team member Chris Chute updated the Committee on the group's progress so far, reporting that they have held one meeting, during which Team members discussed the group's scope. Initially they hoped to talk about public health reporting and all its potential, but a more tactical focus was rapidly agreed upon. The Team decided to deal specifically with immunization with syndromic surveillance. The issue is whether to use HL7 2.3.1 or 2.5.1. in syndromic surveillance, and the need to enhance the implementation guide.

Chute raised the question of whether the Team should be thinking about a next generation of more holistic public health reporting that would address the larger potential scope that they are not at the moment addressing. Are recipients who are not covered by meaningful use requirements—that is, health departments—in a position to receive and handle CDA messages in any meaningful capacity? Could there be some hybrid where results are made more easily available?

The Team must clarify explicitly the distinctions in public health reporting in those two HL7 versions. They plan to survey recipients about their ability to receive 2.5.1, using survey information that is already being collected. They must also explore the technical space for vaccination data, and to look at the capacity to receive CDAs as well.

Discussion

- Walter Suarez noted that it is important to go beyond the constraints of the Team's current priority and examine other valuable areas such as vital statistics reporting. Much work has been done in terms of standardizing messages that go from providers to report births, deaths, and the like. Another significant area is public health case reporting of communicable diseases and other notifiable conditions. This is not syndromic surveillance reporting, but rather the reporting of very specific types of events. In many cases this is much more complex than what is encompassed in syndromic surveillance.

NwHIN Power Team

Power Team Chair Dixie Baker said that the group recommends a modular set of transport security and content components that could be used as building blocks to enable the exchange of

documents at a nationwide level. In defining these components, the emphasis is on simplicity of the components, ease of implementing exchange, and cross-modularity among the components, such that they can build on one another and be integrated together.

The group will offer a preliminary presentation to the HITSC next month, and a final presentation in September.

ONC's Avinash Shanbhag briefed the team on ONCs efforts to evaluate the specifications and standards used by NwHIN Exchange and the Direct Project to determine which are suitable for use as these building blocks. They are developing grids to evaluate NwHIN exchange specifications and mapping the specification grid to levels. Baker presented illustrations of these grids to demonstrate the kind of work that ongoing, noting that the Power Team gave feedback to the S&I Framework on the evaluation criteria.

Discussion

- Walter Suarez commented that the HITPC made a series of recommendations on meaningful use and identified a series of items to bring back to the HITSC in areas relating to stage 2 recommendations that need clarifications or standards. He asked whether they have been mapped to ensure that all of the elements recommended by the HITPC are being covered. He noted especially the work of the Privacy and Security Tiger Team.

- Doug Fridsma reported that the process of transposing this information to ensure that the right policy objectives are met is ongoing. Dialog between NIST and the HITSC is needed. Efforts are being made to ensure all areas are being covered.

6. Implementation Workgroup Update

Implementation Workgroup Co-Chair Liz Johnson commented that as the group looks forward, it must immediately examine clarifications around Stage 1 and make the certification process appropriate. The Workgroup also must look forward to Stage 2, working with ONC and NIST, and examine how to tie together objectives and measures with existing standards. Johnson presented a grid to illustrate this process. The certification process needs to have a strategy and a replicable process for the future.

Discussion

- Dixie Baker pointed out that the grid presented relating to the Privacy and Security Workgroup does not include many Meaningful Use objectives. However, there have been many policy directives handed down that should go into this meaningful use column on the grid, because the recommendations should be folded in to Stage 2.

- Regarding certification criteria, Nancy Orvis said she wanted to clarify whether vendors and other entities come forward to be certified could also be submitting things that are not yet specified under meaningful use Stage 1 or 2. When an organization is trying to buy 3-5 years in advance, they want an idea of whether they are doing something cutting-edge. This is

particularly relevant when it comes to medical devices. Liz Johnson agreed that this is an important question to consider. Perlin concurred, pointing to its relevance in terms of both business logic and policy.

7. Public Comment

Tom Bizarro of First DataBank spoke in support of moving towards an interoperable vocabulary for transmitting health information. Having a single code set reduces complexity and the chance for error. He noted that it is very complex to electronically transmit prescription information. With RxNorm codes, there is a way to represent both generically and as a brand. The group ought to consider why NCPDP chose the SPD the SCD to represent the B-pack and the G-pack unambiguously.

Robin Raiford from AllScripts said that smoking status and demographics are two items that really throw physicians off guard. When Jim Walker showed a list of all the vocabularies, an orphan mandated answer that was left out is ethnicity.

Karen Whitting from IBM questioned a transmittal letter from June that was included in the meeting materials. She asked when the Standards Committee agreed to send the letter, given that the contents seemed contradictory to the discussion that took place during this meeting. Judy Sparrow explained that when recommendations are accepted by the Committee, those recommendations are transmitted to the National Coordinator for Health Information Technology. In response to Whitting's question, Sparrow confirmed that the letter was consistent with the discussions that took place in June.

Melissa Swansell from MediTech discussed standards for medical quality reporting. She suggested the need to look at version control for those standards. For example, regarding Stage 1 quality reporting for hospitals, the current Healthcare Information Technology Standards Panel (HITSP) has outdated RxNorm code. As these standards are implemented, the Committee must look at version control and updating to keep it current, but not so often that it will be difficult to keep pace with changes in nomenclature.

SUMMARY OF ACTION ITEMS:

Action Item #1: The Committee approved by consensus the minutes from the June 22nd meeting with Carol Diamond's corrected attribution.

Action Item #2: The Committee endorsed the ePrescribing of Discharge Medications Power Team's recommendation letter with the two amendments as noted.